

section is equal to \$250 for plan years that end in 2006.

(2) Subject to paragraph (b)(3) of this section, the cost limit under this section is equal to \$5,000 for plan years that end in 2006.

(3) The cost threshold and cost limit specified in paragraphs (b)(1) and (b)(2) of this section, for plan years that end in years after 2006, are adjusted in the same manner as the annual Part D deductible and the annual Part D out-of-pocket threshold are adjusted annually under § 423.104(d)(1)(ii) and (d)(5)(iii)(B), respectively.

**§ 423.888 Payment methods, including provision of necessary information.**

(a) *Basis.* The provisions of § 423.301 through § 423.343, including requirements to provide information necessary to ensure accurate subsidy payments, govern payment under § 423.886 except to the extent the provisions in this section specify otherwise.

(b) *General payment rules.* Payment under § 423.886 is conditioned on provision of accurate information. The information must be submitted, in a form and manner and at the times provided in this paragraph and under other guidance specified by CMS, by the sponsor or its designee.

(1) *Timing.* Payment can be made on a monthly, quarterly or annual basis, as elected by the plansponsor under guidance specified by CMS, unless CMS determines that the options must be restricted because of operational limitations.

(i) *Monthly or quarterly payments.* If the plan sponsor elects for payment on a monthly or quarterly basis, it must provide information described in paragraph (b)(2)(i) of this section on the same monthly or quarterly basis, or at such time as CMS specifies.

(ii) *Annual payments.* If the sponsor elects an annual payment, it must submit to CMS actual rebate and other price concession data within 15 months after the end of the plan year.

(2) *Submission of cost data—(i) Monthly or quarterly payments.* If the plan sponsor elects to receive payment on a monthly or quarterly basis, it must submit to CMS, in a manner specified by CMS, the gross covered retiree plan-related prescription drug costs (as de-

finied in § 423.882) incurred for its qualifying covered retirees during the payment period for which it is claiming a subsidy payment and any other data CMS may require. Except as otherwise provided by CMS in future guidance, the sponsor must also submit, using historical data and generally accepted actuarial principles, an estimate of the extent to which its expected allowable retiree costs differs from the gross covered retiree plan-related prescription drug costs, based on expected rebates and other price concessions for the upcoming plan year. The estimate must be used to reduce the periodic payments for the plan year. Final allocation of price concession data must occur after the end of the year under the reconciliation provisions of paragraph (b)(4) of this section.

(ii) *Annual payments.* If the plan sponsor elects a one-time final annual payment, it must submit, in a manner specified by CMS, within 15 months, or within any other longer time limit specified by CMS, after the end of the plan year, the total gross covered retiree plan-related prescription drug costs (as defined in § 423.882) for the plan year for which it is claiming a subsidy payment, actual rebate and other price concession data described in paragraph (b)(1)(ii) of this section, and any other data CMS may require. The alternative is that the sponsor can elect an interim annual payment, in which case it must submit the following to CMS, at a time and in a manner specified by CMS: the gross covered retiree plan-related prescription drug costs (as defined in § 423.882) incurred for all of its qualifying covered retirees during the payment period for which it is claiming a subsidy payment; an estimate (using historical data and generally accepted actuarial principles) of the difference between such gross costs and allowable costs (based on expected rebates and other price concessions for the upcoming plan year); and any other data CMS may require.

(3) *Payment by CMS.* CMS makes payment after the sponsor's submission of the cost data at a time and in a manner to be specified by CMS.

(4) *Reconciliation.* (i) Sponsors who elect either monthly, quarterly or an interim annual payment must submit

to CMS, within 15 months, or within any other longer time limit specified by CMS, after the end of its plan year, the total gross covered retiree plan-related prescription drug costs (as defined in § 423.882), in a manner specified by CMS; actual rebate and other price concession data for the plan year in question; and any other data CMS may require.

(ii) Upon receiving this data, CMS adjusts the payments made for the plan year in question in a manner to be specified by CMS.

(5) *Special rule for insured plans*—(i) *Interim payments.* Sponsors of group health plans that provide benefits through health insurance coverage (as defined in 45 CFR 144.103) and that choose either monthly payments, quarterly payments or an interim annual payment in paragraphs (b)(1) and (b)(2) of this section, may elect to determine gross covered plan-related retiree prescription drug costs for purposes of the monthly, quarterly or interim annual payments based on a portion of the premium costs paid by the sponsor (or by the qualifying covered retirees) for coverage of the covered retirees under the group health plan. Premium costs that are determined, using generally accepted actuarial principles, may be attributable to the gross covered plan-related retiree prescription drug costs incurred by the health insurance issuer (as defined in 45 CFR 144.103) for the sponsor's qualifying covered retirees, except that administrative costs and risk charges must be subtracted from the premium.

(ii) *Final payments.* At the end of the plan year, actual gross retiree plan-related prescription drug costs incurred by the insurer (or the retiree), and the allowable costs attributable to the gross costs, are determined for each of the sponsor's qualifying covered retirees and submitted for reconciliation after the end of the plan year as specified in paragraph (b)(4) of this section. The data for the reconciliation can be submitted directly to CMS by the insurer in a manner to be specified by CMS. Upon receiving this data, CMS adjusts the payments made for the relevant plan year in a manner to be specified by CMS.

(c) *Use of information provided.* Officers, employees and contractors of the Department of Health and Human Services, including the Office of Inspector General (OIG), may use information collected under this section only for the purposes of, and to the extent necessary in, carrying out this subpart including, but not limited to, determination of payments and payment-related oversight and program integrity activities, or as otherwise required by law. This restriction does not limit OIG authority to conduct audits and evaluations necessary for carrying out these regulations.

(d) *Maintenance of records.* (1) The sponsor of the qualified retiree prescription drug plan (or a designee), as applicable, must maintain, and furnish to CMS or the OIG upon request, the records enumerated in paragraph (d)(3) of this section. The records must be maintained for 6 years after the expiration of the plan year in which the costs were incurred for the purposes of audits and other oversight activities conducted by CMS to assure the accuracy of the actuarial attestation and the accuracy of payments.

(2) CMS or the OIG may extend the 6-year retention requirement for the records enumerated in paragraph (d)(3) of this section in the event of an ongoing investigation, litigation, or negotiation involving civil, administrative or criminal liability. In addition, the sponsor of the qualified retiree prescription drug plan (or a designee), as applicable, must maintain the records enumerated in paragraph (d)(3) of this section longer than 6 years if it knows or should know that the records are the subject of an ongoing investigation, litigation or negotiation involving civil, administrative or criminal liability.

(3) The records that must be retained are:

(i) Reports and working documents of the actuaries who wrote the attestation submitted in accordance with § 423.884(a).

(ii) All documentation of costs incurred and other relevant information utilized for calculating the amount of the subsidy payment made in accordance with § 423.886, including the underlying claims data.

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(iii) Any other records specified by CMS.

(4) CMS may issue additional guidance addressing recordkeeping requirements, including (but not limited to) the use of electronic media.

[70 FR 4525, Jan. 28, 2005, as amended at 74 FR 1549, Jan. 12, 2009]

**§ 423.890 Appeals.**

(a) *Informal written reconsideration—*

(1) *Initial determinations.* A sponsor is entitled to an informal written reconsideration of an adverse initial determination. An initial determination is a determination regarding the following:

(i) The amount of the subsidy payment.

(ii) The actuarial equivalence of the sponsor's retiree prescription drug plan.

(iii) If an enrollee in a retiree prescription drug plan is a qualifying covered retiree; or

(iv) Any other similar determination (as determined by CMS) that affects eligibility for, or the amount of, a subsidy payment.

(2) *Effect of an initial determination regarding the retiree drug subsidy.* An initial determination is final and binding unless reconsidered in accordance with this paragraph (a) of this section.

(3) *Manner and timing for request.* A request for reconsideration must be made in writing and filed with CMS within 15 days of the date on the notice of adverse determination.

(4) *Content of request.* The request for reconsideration must specify the findings or issues with which the sponsor disagrees and the reasons for the disagreements. The request for reconsideration may include additional documentary evidence the sponsor wishes CMS to consider.

(5) *Conduct of informal written reconsideration.* In conducting the reconsideration, CMS reviews the subsidy determination, the evidence and findings upon which it was based, and any other written evidence submitted by the sponsor or by CMS before notice of the reconsidered determination is made.

(6) *Decision of the informal written reconsideration.* CMS informs the sponsor of the decision orally or through electronic mail. CMS sends a written deci-

sion to the sponsor on the sponsor's request.

(7) *Effect of CMS informal written reconsideration.* A reconsideration decision, whether delivered orally or in writing, is final and binding unless a request for hearing is filed in accordance with paragraph (b) of this section, or it is revised in accordance paragraph (d) of this section.

(b) *Right to informal hearing.* A sponsor dissatisfied with the CMS reconsideration decision is entitled to an informal hearing as provided in this section.

(1) *Manner and timing for request.* A request for a hearing must be made in writing and filed with CMS within 15 days of the date the sponsor receives the CMS reconsideration decision.

(2) *Content of request.* The request for informal hearing must include a copy of the CMS reconsideration decision (if any) and must specify the findings or issues in the decision with which the sponsor disagrees and the reasons for the disagreements.

(3) *Informal hearing procedures.* (i) CMS provides written notice of the time and place of the informal hearing at least 10 days before the scheduled date.

(ii) The hearing is conducted by a CMS hearing officer who neither receives testimony nor accepts any new evidence that was not presented with the reconsideration request. The CMS hearing officer is limited to the review of the record that was before CMS when CMS made both its initial and reconsideration determinations.

(iii) If CMS did not issue a written reconsideration decision, the hearing officer may request, but not require, a written statement from CMS or its contractors explaining CMS' determination, or CMS or its contractors may, on their own, submit the written statement to the hearing officer. Failure of CMS to submit a written statement does not result in any adverse findings against CMS and may not in any way be taken into account by the hearing officer in reaching a decision.

(4) *Decision of the CMS hearing officer.* The CMS hearing officer decides the case and sends a written decision to the sponsor, explaining the basis for the decision.

(5) *Effect of hearing officer decision.* The hearing officer decision is final